

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06858 150

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County

Calvert

City or town

Port Republic.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Alberta Chase.

4. Sex

F

5. Color or race

C

6.(a) Single, married, widowed, or divorced

X

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

T

1891

8. AGE:

56

Years

Months

Days

If less than one day

hre.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Domestic

11. Industry or business

MOTHER FATHER

12. Name

John Beden

13. Birthplace

Md

14. Maiden name

Margaret Chase

15. Birthplace

Md

16. Informant

Dick Chase

Address

Huntingtown

17. Burial

Date thereof 8-5-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Patuxent

Location

Calvert

18. Funeral director

P. E. Sewell

Address

Princ Frederick and.

19. (Date rec'd by registrar)

19-47

78-W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Calvert

City or town

Port Republic.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

8-2-47 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19..... to 19.....

and that I last saw h... alive on

19.....

Immediate cause of death

General Anesthesia

DURATION

Jan 1947

Due to Cardiac Decompression

Mar 1947

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

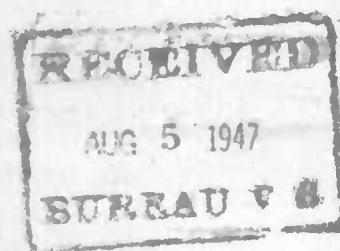
Means of injury

Injured at work?

23. SIGNATURE

Doge S. D. M. D. or other

Address John Murdoch Date signed 8/3/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

668595+

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County

City or town

*Baltimore**Willowood Md*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Avalia Saxon

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

F C M

6.(b) Name of husband or wife

Benjamin Saxon

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

November 18/1896

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

Willowood Baltimore Md

10. Usual occupation

Housewife

11. Industry or business

Thomas Tayan

MOTHER

FATHER

12. Name

Leahert County

13. Birthplace

Christiansburg Tayan

MOTHER

FATHER

14. Maiden name

Leahert County

15. Birthplace

Leahert County

MOTHER

FATHER

16. Informant

Benjamin Saxon

Address

Willowood, Maryland

MOTHER

FATHER

17. Cemetery or crematory

H. E. Edmonds

Location

Willowood Md

18. Funeral director

Stanley Sewell

Address

Prince Frederick Md

19. Date rec'd by registrar

8-27 1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

August 27 1947 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

to

and that I last saw h. alive on

19.

Immediate cause of death

DURATION

*Pulmonary hemorrhage 2 min.*Due to *Cause unknown (10/1/47 as.)*

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

injured at work?

23. SIGNATURE

H. Lee Sand

M. D. or other

Address

George W. Lep

Date signed

RECEIVED

SEP 6 1947

BUREAU F B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. If incorrect age is especially important, please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0686(153)

CERTIFICATE OF DEATH

93d
Reg. Dist. No. 51

1. PLACE OF DEATH:

County.....

Calvert

City or town.....

N. Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

5 days

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Jennie M Friedheim

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife.....

Victor J. Friedheim

7. Birth date of deceased (mo., day, yr.)

8/24/47

8. (c) If alive, give age..... years

8. AGE: Years

62

Months

10

Days

-

It less than one day

hrs.

min.

9. Birthplace.....

D.C.

(Town, county, and state)

10. Usual occupation.....

Wife

11. Industry or business.....

Home

MOTHER

12. Name.....

Jennie E. Hedges

FATHER

13. Birthplace.....

Balto. Md

14. Maiden name.....

Jennie M McMagie

15. Birthplace.....

D.C.

16. Informant.....

Mrs. Hodges

Address

N. Beach

17. Burial

Date thereof.....

8/27/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Congregational Cem.

Location.....

D.C.

18. Funeral director.....

S. H. Hines Co

Address

2901 14th St N.W. D.C.

19. Date rec'd by registrar

8-25 1947

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

D.C.

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2844

Vista St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

8/24

1947 at 10³⁰ A.M.

20. DATE OF DEATH.....

I CERTIFY that death occurred on the date above stated; that I attended deceased from

8/24 1947 to 8/24 1947

and that I last saw her.....alive on 8/24/47 1947

Immediate cause of death.....

chi. myocarditis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Huntington Rd Date signed 8/28/47



PLEASE WRITE PLAINLY, WITH
FADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06861

17

CERTIFICATE OF DEATH

Reg. Dist. No. 5-2

1. PLACE OF DEATH:

County CalvertCity or town Chesapeake Beach
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Jerome Gorman4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced7. Birth date of deceased (mo. day, yr.) Aug. 7, 19188. AGE: Years 1 Months Days 23 If less than one day hrs. min. 9. Birthplace Calvert (Town, county, and state)

10. Usual occupation:

11. Industry or business

12. Name Hubert Gorman13. Birthplace Calvert, Md.14. Maiden name Edna Chase15. Birthplace Md.16. Informant Louise ChaseAddress Chesapeake Beach17. Burial Date thereof 8-31-47
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. EdmundsLocation Md.18. Funeral director P.C. SewellAddress Prince Frederick Md.19. Date rec'd by registrar August 31, 1947 Virginia Carpenter Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County CalvertCity or town Chesapeake Beach
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2. (a) If veteran, name war: _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 30, 1947, at 5 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/29 to 8/30, and that I last saw him alive on 8/29.

Immediate cause of death:

Bronchitis pneumonia

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

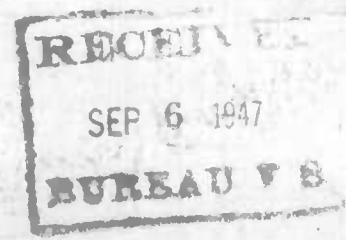
Means of injury

Injured at work?

23. SIGNATURE Oliver Gorman

M. D. or other

Address Huntington Md. Date signed 8/30/47





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0686252

CERTIFICATE OF DEATH

1310
Reg. Dist. No. 51

1. PLACE OF DEATH:

County

Calvert

City or town

Plum Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

J. Wilson Ireland

3. (b) Social Security Number

No

4. Sex

M

5. Color of face

W

6. (a) Single, married, widowed, or divorced

M.

8. (b) Name of husband or wife

Mary Ireland

7. Birth date of deceased (mo., day, yr.)

Mar. 9, 1868

8. (c) If alive, give age 66 years

8. AGE:

79

Years

5

Months

7

Days

If less than one day

hrs.

min.

9. Birthplace

Plum Point, Md.

(Town, county, and state)

10. Usual occupation

Farming

11. Industry or business

MOTHER FATHER

Edward J. Ireland

MOTHER

Calvert Co., Md.

12. Name

Calvert Co., Md.

13. Birthplace

Elizabethtown, Md.

14. Maiden name

Elizabeth Gibson

15. Birthplace

Calvert Co., Md.

16. Informant

Herbert Ireland

Address

Plum Point, Md.

17. Burial

Burial

Date thereof

Aug. 18, 1947

(month) (day) (year)

Cemetery or Crematory

Christ Church

Location

Port Republic, Md.

18. Funeral director

A. O. Darkness & Son

Address

Mutual, Md.

19. Date rec'd by registrar

8-18

1947

Date

H. W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Calvert

City or town

Plum Point

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

no

MEDICAL CERTIFICATION

2D. DATE OF DEATH

8/16

1947

at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/1

1947

to

8/16

1947

and that I last saw h. in alive on

8/15

1947

Immediate cause of death

Hypertensive cardiac vascular

rural disease

Due to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H. W. Ward

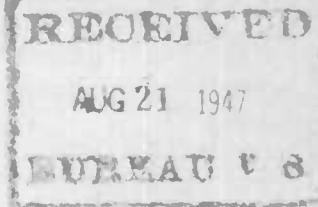
M. D. or other

Address

Huntingtown

Date signed

8/16/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06863

15

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH: Calvert
 County.....
 City or town.....Lower Marlboro
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? L
 Hospital, Institution, or street address where death occurred:

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State.....Md County.....Cal
 City or town.....Lower Marlboro
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war: _____

3. (a) FULL NAME
Thomas S. King

3. (b) Social Security Number

4. Sex <u>M.</u>	5. Color or race <u>W</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
------------------	---------------------------	---

B. (b) Name of husband or wife Martha E

7. Birth date of deceased (mo., day, yr.) 31 Jan 1907
 6. (c) If alive, give age 34 years

8. AGE: Years 40 Months _____ Days _____ If less than one day _____
 hrs. _____ min. _____

9. Birthplace Lower Marlboro
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

MOTHER FATHER
 12. Name Geo. C. King

13. Birthplace Md

14. Maiden name Lydia M. Younger

15. Birthplace Md

16. Informant mrs. Ireland

Address Plum Point

17. Burial Cemetery Date thereof Aug. 10, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cemetery

Location Lower Marlboro Md.

18. Funeral director W. H. Hutchins

Address Owings Md.

19. Cremated 9 1947 Elsie M. Cox

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Aug 1947 at 5:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8 Aug 1947 to 8 Aug 1947

and that I last saw him alive on 8 Aug 1947

Immediate cause of death coronary sclerosis

DURATION _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings or operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. DeGraw Jr. M. D. or other _____

Date signed 9/9/47

Address Huntington town



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

06864

155

51

1. PLACE OF DEATH:

County.....

City or town.....

Calvert
Chesapeake Beach

(If outside city or town limits, write RURAL and give nearest town)

How long is above place of death?

Hospital, institution, or street address where death occurred:

How long is hospital or institution?

3. (a) FULL NAME

Richard G. Pace

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

w

Married

6. (b) Name of husband or wife.....

Jean Pace

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state) Virginia

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name..... Lorenta Pace

13. Birthplace..... Virginia

14. Maiden name..... Eliza Jones

15. Birthplace..... Virginia

16. Informant.....

Address.....

17. Burial.....

(Burial, cremation, or removal. Which?)

Date thereof..... 9 - 2 - 47
(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

8 - 31 1947

(Date rec'd by registrar)

H. W. Ward
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

D.C. County.....

City or town.....

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

2703. Harsens St., N.E.

(If rural, give LOCATION)

2.(a) If veteran, same war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Aug 30 1947 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him..... alive on.....

Immediate cause of death.....

drowning

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... accident Date of 8-30-47

Where did injury occur?..... Calvert Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)..... public place

Means of injury..... free from heat injured at work?..... No

23. SIGNATURE.....

Ola H. Ward M. D. or other

Address..... Young Rd. Date signed.....

RECEIVED

SEP 6 1947

BUREAU # 8



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170c

151
06865

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County Calvert
City or town Paris, md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Henry H Parker

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

m

C

X

6.(b) Name of husband or wife

Annie M. Parker

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.)

March 16, 1882

8. AGE:

Years 65

Months

Days

If less than one day

hrs. min.

9. Birthplace

md

(Town, county, and state)

10. Usual occupation

farmer.

11. Industry or business

David Parker.

MOTHER FATHER

12. Name

Annie M. Parker.

13. Birthplace

md

14. Maiden name

Suzie Ann Collins

15. Birthplace

md

16. Informant

Annie M. Parker.

Address

Prince Frederick, md

17. Burial

Date thereof 8-12-47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Brown's

Location

Calvert

18. Funeral director

P. E. Sewell

Address

Prince Frederick

19. Date rec'd by registrar

Aug 11 1947

H. W. Ward

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

md

County

Calvert-

City or town

Prince Frederick, md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1947 230 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

10...

to 19...

and that I last saw him alive on

19...

Immediate cause of death

Crashed Chest

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Accidental Date of 8-10-47

Where did injury occur? Paris Calvert md

(City or town) (County) (State)

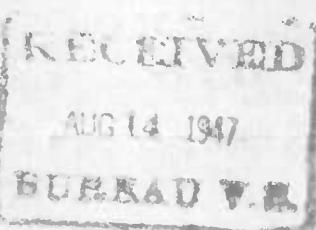
Injured at home, farm, industry, public place (where?) Public road

Means of injury Auto accident Injured at work? No

23. SIGNATURE

H. W. Ward M. D. or other

Address Owings, md Date signed 8/11/47



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06866

CERTIFICATE OF DEATH

Reg. Dia. No. 50

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

John Parran

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

M

6. (b) Name of husband or wife

Ella Sarah Parran

7. Birth date of deceased (mo., day, yr.)

Feb. 12, 1864

6. (c) If alive, give age 73 years

8. AGE:

Years

Months

Days

If less than one day

83

5

25

hrs.

min.

9. Birthplace.....

Calvert Co., Md.

(Town, county, and state)

10. Usual occupation.....

Farming

11. Industry or business

Thomas Parran

MOTHER FATHER

12. Name.....

Calvert Co., Md.

13. Birthplace

Mary E. Collins

14. Maiden name.....

Calvert Co., Md.

15. Birthplace

Mrs. John Parran

16. Informant.....

Burial

Address

Bunil

Date thereof Aug. 9, 1947
(month day year)

17. (Burial, cremation, or removal. Which?)

Middleham Chapel

Cemetery or crematory

Bunil, Md.

Location

G. A. Starkness & Son

18. Funeral director

Mutual Md.

Address

Aug. 9th, 1947

19. (Date rec'd by registrar)

G. G. Sanders

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

3rd

County.....

Calvert

City or town.....

Bunil

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

924

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

700

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Aug. 7, 1947 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 2, 1947, to Aug. 7, 1947
and that I last saw h. i.m. alive on Aug. 7, 1947

Immediate cause of death.....

Acute congestion of lung -

Due to.....

Failure of heart

Due to.....

Secondary arterioclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

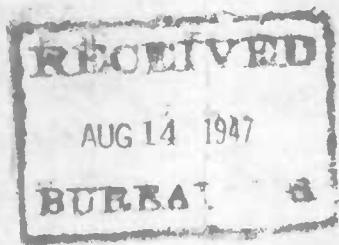
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.....

S. L. Devillars M. D. or other

Address..... S. L. Devillars, M. D. Date signed Aug. 1947



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

16

CERTIFICATE OF DEATH

Reg. Dist. No. 52

06867

1. PLACE OF DEATH

County.....

Calvert

City or town.....

Ches. Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

3 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

William Reid Payne

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

S

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.)

June 2, 1941

6.(c) If alive, give age..... years

8. AGE: Years

6

Months

-

Days

-

If less than one day

hrs.

min.

9. Birthplace..... Kentucky

(Town, County, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name..... Thornton J. Payne

13. Birthplace..... Kentucky

14. Maiden name..... Jean E. Reis

15. Birthplace..... Kentucky

16. Informant..... Mr. Thornton Payne

Address..... Chesapeake Beach Md.

17. Burial.....

(Burial, cremation, or removal, which?)

Date thereof..... 8/14/47

(month) (day) (year)

Cemetery or crematory..... Mt. Sterling

Location..... Kentucky

18. Funeral director..... Wm. F. Hutchins

Address..... Owings Md.

19. Aug. 12 1947 Date registered by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Calvert

170c

County.....

City or town.....

Ches. Beach

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

8/11 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

19.....

Immediate cause of death.....

Crushed chest

Due to.....

Auto accident

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

date of.....

Where did injury occur?..... Calvert

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Auto accident

Injured at work?

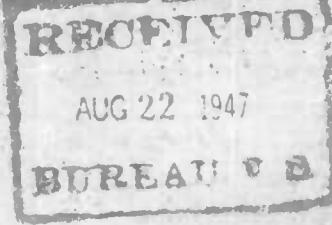
23. SIGNATURE.....

H. Ward

M. D. or other

Address..... Burying Place

Date signed..... 8/13/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct size is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0686818

CERTIFICATE OF DEATH

Reg. Dlat. No. 52

1. PLACE OF DEATH:

County.....

Chesapeake
Calvert Co

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Carl Philip Reuben Persinger

4. Sex

m

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

June 28, 1929

6. (c) If alive, give age..... years

8. AGE: Years

18

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

W Va

millwork

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER

12. Name.....

James H. Persinger

13. Birthplace.....

W Va

W Va

W Va

W Va

W Va

14. Maiden name.....

Linsinger Brag

Linsinger Brag

Linsinger Brag

Linsinger Brag

15. Birthplace.....

W Va

W Va

W Va

16. Informant.....

John H. Persinger

John H. Persinger

John H. Persinger

Address.....

Gambrells Md.

Gambrells Md.

Gambrells Md.

17. (Burial, cremation, or removal. When?)

Burial

Cremation

Removal

Date thereof.....

(month) (day) (year)

8/31/47

Brown

RECEIVED

SEP 6 1947

BUREAU F.B.I.

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

CERTIFICATE OF DEATH

Reg. Dist. No.

#159

506869

1. PLACE OF DEATH: Calvert
County.....
City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Robert E. Seibels Jr. U.S.N

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Jule Seibels Seibels

7. Birth date of deceased (mo., day, yr.) 2-20-17 6. (c) If alive, give age 28 years

8. AGE: Years 30 Months Days It less than one day hrs. min.

9. Birthplace Alabama (Town, county, and state)

10. Usual occupation U.S. Navy officer

11. Industry or business

12. Name Robert E. Seibels Jr. Seibels

13. Birthplace Unknown

14. Maiden name Frances Lockette Marks

15. Birthplace Unknown

16. Informant Navy Records

17. Address U.S. N. Air Station - Patuxent River Md

(Burial, cremation, or removal. Which?) Date thereof 9-3-47 (month) (day) (year)

Cemetery or crematory Oakwood

Location Montgomery, Alabama

18. Funeral director Robins' Funeral Home

Address Leonardtown, Md

19. 8-30 1947 N.W. Clegg
(Date rec'd by registrar)2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Cal Maryland

City or town Patuxent Naval Air Station
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____ (If rural, give LOCATION)

2.(a) If veteran, name war WW II ✓

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 8/30 1947 at 2 42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from accidental death and that I last saw him alive on 19. 10. 19. 19.

Immediate cause of death Fracture of skull

3 1/2 degree burns

Due to Aeroplane accident

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8/30/47

Where did injury occur? Dares Cal Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Farm

Means of injury Plane crash Injured at work yes

23. SIGNATURE Alvin Clegg

M. D. or other Huntingtown Date signed 8/30/47

Address 1019 Med. Examinee

